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Section 3.17 **Transition of Persons**

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3.17.1 Introduction

Persons receiving behavioral health services in the ADHS/DBHS system may experience transitions during the course of their care and treatment. Examples of transitions of care include changing service providers, establishing eligibility under Arizona Long Term Care Services (ALTCS), transitioning into adulthood, and moving out of the T/RBHA's geographic service area. During transitions of care, behavioral health providers must ensure that services are not interrupted and that the person continues to receive needed behavioral health services. Coordination and continuity of care during transitions are essential in maintaining a person's stability and avoiding relapse or decompensation in functioning.

The intent of this section is to:

- Identify the situations that require a transition of care;
- Describe expectations for providers when initiating or accepting a transition of care for an enrolled person; and
- Identify resources to assist behavioral health providers in supporting a person who is experiencing a transition of care.

3.17.2 References

The following citations can serve as additional resources for this content area:

[A.R.S. § 36, Chapter 5](#)
[9 A.A.C. 21, Article 5](#)
[AHCCCS/ADHS Contract](#)
[ADHS/RBHA Contract](#)
[ADHS/Gila River Health Care Corporation Intergovernmental Agreement](#)
[ADHS/Pascua Yaqui Behavioral Health Program Intergovernmental Agreement](#)
[SMI Eligibility Determination Section](#)
[Disclosure of Behavioral Health Information Section](#)
[Service Prioritization for Non-Title XIX/XXI Funding Section](#)
[Co-payments Section](#)

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[Notice and Appeal Requirements \(SMI and Non-SMI/Non-Title XIX/XXI\) Section](#)
[Outreach, Engagement, Re-Engagement and Closure Section](#)
[Enrollment, Disenrollment and other Data Submission Section](#)
[Clinical Liaison Section](#)
[Appointment Standards and Timeliness of Services Section](#)
[Pre-petition Screening, Court Ordered Evaluation and Treatment Section](#)
[Transitioning to Adult Services Practice Improvement Protocol](#)
[ADHS/DBHS Policy Clarification Memorandum: Inter-RBHA Coordination of Service](#)

3.17.3 Scope

To whom does this apply?

All persons currently enrolled with a T/RBHA and experiencing a transition of care.

3.17.4 Did you know...?

- Some persons may experience a transition of payers, but not actually change providers. This could happen, for example, when a Title XIX behavioral health recipient moves from an AHCCCS acute care Health Plan to the ALTCS program. Many ALTCS Program Contractors for the elderly and physically disabled (ALTCS/EPD) contract with the same behavioral health providers as the T/RBHAs. This kind of transition, where fiscal responsibility changes but not the provider, may be transparent to the person receiving services, but could result in administrative changes for the provider (e.g., submitting claims or bills to the ALTCS Program Contractor versus submitting an encounter as a T/RBHA provider).
- The ALTCS program is considered a “carve-in model,” a service delivery model that assigns coverage of medical and behavioral health services through a single entity (i.e., Program Contractor). An exception to this “carve-in model” is the delivery of covered behavioral health services for persons eligible for ALTCS through the Division of Developmental Disabilities (DDD). ALTCS/DDD eligible persons receive covered behavioral health services through the RBHAs and their subcontracted behavioral health providers.

3.17.5 Objectives

To ensure the coordination and continuity of care for persons experiencing a transition in service providers.

3.17.6 Definitions

[Behavioral Health Category Assignment](#)

[Clinical Liaison](#)

[Designated T/RBHA](#)

[Home T/RBHA](#)

[Independent Living Setting](#)

[Institution for Mental Disease \(IMD\)](#)

[Out-of-area service](#)

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[Residence](#)

[Serious Mental Illness \(SMI\)](#)

[Transfer](#)

3.17.7 Procedures

3.17.7-A. Transition from child to adult services

When a child who has been involved in long term or intensive behavioral health care reaches the age of 16, planning for the transition into the adult behavioral health system must begin. A transition plan that starts with an assessment of self-care and independent living skills, social skills, work and education plans, earning potential and psychiatric stability must be incorporated in the child's individual service plan.

What elements should be addressed as part of the child's transition plan?

Some of the elements to be addressed by the Child and Family Team and/or Clinical Liaison as part of a transition plan include:

- What are likely to be the child's behavioral health needs into adulthood?
- What personal strengths will assist the child when he/she transitions to the adult system?
- Will there be a change in provider, the clinical team, family involvement, and/or the clinical liaison? How will the transition be implemented?
- Where will the child reside upon turning 18 and how will he/she support him/herself?
- Will the child need referrals to and assistance with applications for Supplemental Security Income (SSI), Rehabilitation Services Administration (RSA), Serious Mental Illness (SMI) eligibility determination, Title XIX and Title XXI eligibility, housing, guardianship, training programs, etc.? Are there medical and school records to substantiate these needs? Begin to gather necessary information to expedite these applications/determinations when the time comes to actually apply. Develop a timeline and task list for when appointments are needed.
- Will the child have or need transportation to appointments and other necessary activities?
- Does the child have special needs or will the child require special assistance services?
- Does the child have appropriate life skills, social skills and employment or education plans?
- What actions need to be taken if the child is not eligible for Title XIX or Title XXI benefits and/or Social Security Disability Income (SSDI) and is not determined to have a serious mental illness?
- What supports need to be in place for a successful transition?
- If an SMI eligibility determination is made, consider initiating a referral for housing, if needed.

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What needs to happen during the year before the child transitions to adult services?

- When a child receiving behavioral health services reaches the age of 17, behavioral health providers must determine whether the child is potentially eligible for services as an adult with a serious mental illness. If so, behavioral health providers must refer the child for an SMI eligibility determination pursuant to [Section 3.10, SMI Eligibility Determination](#).
- When a child receiving behavioral health services reaches 17 and a half, the Child and Family Team and/or the clinical liaison must:
 - Assist the child and/or family or guardian in applying for potential benefits (e.g., SSI, food stamps, etc.);
 - Assist the child and/or family in applying for Title XIX or Title XXI benefits; if the child and/or family is already eligible, determine if eligibility will continue for the child once he/she turns 18;
 - Address any new authorization requirements for sharing protected health information due to the child turning 18 (as described in [Section 4.1, Disclosure of Behavioral Health Information](#)) to ensure that the clinical team can continue to share information;
 - Ensure that the child's behavioral health category assignment is changed consistent with [Section 7.5, Enrollment, Disenrollment and other Data Submission](#). Once the child's behavioral health category assignment has been changed, ongoing behavioral health service appointments must be provided according to the timeframes for routine appointments in [Section 3.2, Appointment Standards and Timeliness of Services](#); and
 - Upon turning 18 years of age, if the person is not eligible for services as a person determined to have a serious mental illness or the person has been determined ineligible for Title XIX or Title XXI services, behavioral health providers can continue to provide behavioral health services consistent with [Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding](#) and [Section 3.4, Co-payments](#).

3.17.7-B. Transition due to a change of the clinical liaison, a provider or the behavioral health category assignment

Upon changes of a person's clinical liaison, provider or behavioral health category assignment, the clinical liaison must:

- Review the current individual service plan and, if needed, coordinate the development of a revised individual service plan with the person, clinical team and the receiving clinical liaison;
- Ensure that the person's comprehensive clinical record is transitioned to the receiving clinical liaison;
- Ensure the transfer of responsibility for court ordered treatment, if applicable; and
- Coordinate the transfer of any other relevant information between clinical liaisons and provider agencies, if needed.

[T/RBHA insert specific information here]

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3.17.7-C. Transition to ALTCS Program Contractors

This section does not apply to persons enrolled in the Arizona Long Term Care Services/Division of Developmental Disabilities (ALTCS/DDD). ALTCS/DDD eligible persons receive all covered behavioral health services through T/RBHAs and their contracted providers.

Once a person is determined eligible and becomes enrolled with the Arizona Long Term Care Services/Elderly or Physically Disabled (ALTCS/EPD) Program, behavioral health providers must not submit claims or encounters for Title XIX covered services to the T/RBHA. To determine if a person is ALTCS/EPD eligible, **[RBHA insert contact information where providers call to find out if a person is ALTCS/EPD eligible]**. The behavioral health provider must, however, continue to provide and encounter needed non-Title XIX covered SMI services (e.g. housing) to persons determined to have a serious mental illness.

Behavioral health providers who contract as an ALTCS provider must not submit encounters for an ALTCS/EPD enrolled person to the RBHA after a person transfers to ALTCS, but must submit bills/claims for payment to the ALTCS Program Contractor who in turn submits the encounters to AHCCCS.

When a person who has been receiving behavioral health services through the T/RBHA becomes enrolled in the ALTCS Program, the clinical liaison must:

- Include the member in transition planning and provide any available information about changes in physician, services, etc.;
- Ensure that the clinical and fiscal responsibility for Title XIX behavioral health services shifts to the ALTCS Program Contractor;
- Provide information to the ALTCS Program Contractor regarding the person's on-going needs for behavioral health services to ensure continuity of care during the transition period;
- Review the current treatment plan and, if needed, coordinate the development of a revised treatment plan with the clinical team and the receiving ALTCS provider and/or case manager;
- Transfer responsibility for any court ordered treatment;
- Coordinate the transfer of records to the ALTCS program contractor; and
- Provide information as follows:
 - For Title XIX eligible 21-64 year olds, the number of days the person has received services in an Institution for Mental Disease (IMD) in the contract year (July 1 – June 30);
 - For all persons, the number of hours of respite received in the contract year (July 1 – June 30); and
 - Whether there is a signed authorization for the release of information contained in the comprehensive behavioral health record pursuant to [Section 4.1, Disclosure of Behavioral Health Information](#).

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3.17.7-D Inter-T/RBHA Transfer

How is T/RBHA responsibility determined for adults?

For adults (persons 18 years and older), T/RBHA responsibility is determined by the adult person's current place of residence, *except* in the following situation:

- Persons who are unable to live independently must not be transferred to another T/RBHA with the exception of persons who are unable to live independently but are involved with the Division of Developmental Disabilities (DDD). Persons involved with DDD who reside in a supervised setting are the responsibility of the T/RBHA in which the supervised setting is located. This is true regardless of where the adult guardian lives.

How is T/RBHA responsibility determined for children?

- For children (ages 0-17 years), T/RBHA responsibility is determined by the current place of residence of the child's parent(s) or legal guardian; and
- For children who have been adjudicated as dependent by a court, the location of the child's court of jurisdiction determines which T/RBHA has responsibility.

How is T/RBHA responsibility determined for persons who are temporarily residing in another T/RBHA's geographic service area?

The home T/RBHA remains fiscally responsible for all services provided to an enrolled person who is visiting or otherwise temporarily residing in a different T/RBHA's geographic service area as long as the person, or legal guardian for a child, maintains a place of residence in the home T/RBHA's geographic service area and intends to return. If the person, or legal guardian for a child, continues to reside in the new location after 3 months, the provider or T/RBHA may proceed with an Inter-T/RBHA transfer if the person, or legal guardian for a child, is consulted and agrees to the change. Only persons who are able to live independently, with the exception of persons who are unable to live independently but are involved with the Division of Developmental Disabilities (DDD), can be transferred.

Crisis services must be provided without regard to the person's enrollment status. When a person presents for crisis services, the T/RBHA or their contracted providers must:

- Provide needed crisis services;
- Ascertain the person's enrollment status with all T/RBHAs and determine whether the person's residence in the current area is temporary or permanent.

If the person is enrolled with another T/RBHA, notify the home T/RBHA within 24 hours of the person's presentation. The home T/RBHA or their contracted providers is fiscally responsible for crisis services and must:

- Make arrangements with the T/RBHA at which the person presents to provide needed services, funded by the home T/RBHA;
- Arrange transportation to return the person to the home T/RBHA area; or
- Determine if the person intends to live in the new T/RBHA's geographic service area and if so, initiate a transfer.

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If the person is not enrolled with any T/RBHA and lives within the service area of the T/RBHA in which the person presented for services, behavioral health providers must notify the T/RBHA to initiate an enrollment.

[T/RBHA insert specific information here]

If the person is not enrolled with a T/RBHA, lives outside of the service area in which he/she presents and requires services other than a crisis or urgent response to a hospital, the T/RBHA or their contracted providers must notify the designated T/RBHA associated with the person's residence within 24 hours of the person's presentation. The designated T/RBHA must proceed with the person's enrollment if the person is determined eligible for services. The designated T/RBHA is fiscally responsible for the provision of all medically necessary covered services, including transportation services, for eligible persons.

What if a T/RBHA or provider receives a referral for a hospitalized person?

In the event that a T/RBHA or provider receives a referral regarding a hospitalized person whose residence is located outside the T/RBHA's geographic service area, the T/RBHA or provider must immediately coordinate the referral with the person's designated T/RBHA.

When is an Inter-T/RBHA Transfer required?

- An Inter-T/RBHA transfer must be completed when: An adult person voluntarily elects to change his/her place of residence to an independent living setting from one T/RBHA's area to another. Only adult persons who are able to live independently can be transferred to another T/RBHA, with the exception of persons who are unable to live independently but are involved with DDD. Adult persons involved with DDD who reside in a supervised setting are the responsibility of the T/RBHA in which the supervised setting is located;
- DDD transfers an adult person who is unable to live independently, but involved with DDD, to another placement;
- The parent(s) or legal guardian(s) of a child change their place of residence to another T/RBHA's area; or
- The court of jurisdiction of a dependent child changes to another T/RBHA's area.

What are the timeframes for initiating an Inter-T/RBHA transfer?

The home T/RBHA or its contracted providers must initiate a referral for an Inter-T/RBHA transfer within the following timeframes:

- At least 30 days prior to the date on which the person will move to the new area; or
- If the planned move is in less than 30 days, immediately upon learning of the person's intent to move.

What are the responsibilities of the receiving T/RBHA during an Inter-T/RBHA transfer?

Within 14 days of receipt of the referral for an Inter-T/RBHA transfer, the receiving T/RBHA or its subcontracted providers must:

- Schedule a meeting to establish a transition plan for the person. The meeting must include:
 - The person or the person's guardian or parent, if applicable;

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- Representatives from the home T/RBHA;
 - Representatives from the Arizona State Hospital, when applicable;
 - The Clinical Liaison and representatives of the child and family team/adult clinical team;
 - Other involved agencies; and
 - Any other relevant participant at the person's request or with the consent of the person's guardian.
- Establish a transition plan that includes at least the following:
 - The person's projected moving date and place of residence;
 - Treatment and support services needed by the person and the timeframe within which the services are needed;
 - A determination of the need to request a change of venue for court ordered treatment and who is responsible for making the request to the court, if applicable;
 - Information to be provided to the person regarding how to access services immediately upon relocation;
 - The enrollment date, time and place at the receiving T/RBHA and the formal date of transfer, if different from the enrollment date;
 - The date and location of the person's first service appointment in the receiving T/RBHA's geographic service area;
 - The individual responsible for coordinating any needed change of health plan enrollment, primary care provider assignment and medication coverage;
 - The person's Clinical Liaison in the receiving T/RBHA's geographic service area, including information on how to contact the Clinical Liaison;
 - Identification of the person at the receiving T/RBHA who is responsible for coordination of the transfer, if other than the person's Clinical Liaison;
 - Identification of any special authorization required for any recommended service (e.g., non-formulary medications) and the individual who is responsible for obtaining needed authorizations; and
 - If the person is taking medications prescribed for the person's behavioral health issue, the location and date of the person's first appointment with a practitioner who can prescribe medications. There must not be a gap in the availability of prescribed medications to the person.

Who is responsible for initiating an Inter-T/RBHA transfer?

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[T/RBHA insert specific information here – who is responsible for this?]

What are the Clinical Liaison's responsibilities during an Inter-T/RBHA transfer?

As part of an Inter-T/RBHA transfer, the clinical liaison must:

- Include the person in transition planning and provide any available information about changes in physician, services, etc.;
- Provide information regarding the person's on-going needs for behavioral health services to ensure continuity of care during the transition period;
- Review the current treatment plan and, if needed, coordinate the development of a revised treatment plan with the clinical team and the receiving provider;
- Transfer responsibility for any court ordered treatment;
- Coordinate the transfer of records to the new clinical liaison; and
- Provide information as follows:
 - For Title XIX eligible 21-64 year olds, the number of days the person has received services in an Institution for Mental Disease (IMD) in the contract year (July 1 – June 30);
 - For all persons, the number of hours of respite received in the contract year (July 1 – June 30); and
 - Any signed authorizations for the release of information contained in the person's comprehensive clinical record pursuant to [Section 4.1, Disclosure of Behavioral Health Information](#).

What are the timeframes for completing an Inter-T/RBHA transfer?

When an Inter-T/RBHA transfer occurs, the person must be disenrolled from the home T/RBHA and enrolled in the receiving T/RBHA contingent upon the date the person expects to relocate to the receiving T/RBHA's geographic service area, but no later than 30 days of the referral by the home T/RBHA (see [Section 7.5, Enrollment, Disenrollment and Other Data Submission](#)). This timeframe allows sufficient time for the receiving T/RBHA to arrange for services and plan the person's transition.

Who is responsible for care during an Inter-T/RBHA transfer?

In an Inter-T/RBHA transfer, the home T/RBHA and its contracted providers retain responsibility for service provision and coordination of care until such time as a person's record is closed for that T/RBHA (see [Section 3.8, Outreach, Engagement, Re-engagement and Closure](#)). The receiving T/RBHA must not delay the timely processing of an Inter-T/RBHA transfer because of missing or incomplete information.

Courtesy Dosing of Methadone

A person receiving methadone administration services who is not a recipient of take-home medication may receive up to two courtesy doses of methadone from a T/RBHA or its contracted providers while the person is traveling outside of the home T/RBHA area. All incidents of

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provision of courtesy dosing shall be reported to the home T/RBHA. The home T/RBHA shall reimburse the behavioral health provider providing the courtesy doses upon receipt of properly submitted bills or encounters.

Appeals for Out-of-Area Service Provision

Persons determined to have a serious mental illness who are the subject of a request for out-of-area service provision or Inter-T/RBHA transfer may file an appeal in accordance with [Section 5.5, Notice and Appeal Requirements \(SMI and Non-SMI/Non-Title XIX/XXI\)](#).

3.17.7-E. Transitions of persons receiving court ordered services

This section pertains to court ordered treatment under [A.R.S. § 36, Chapter 5](#) (see [Section 3.18, Pre-petition Screening, Court Ordered Evaluation and Treatment](#)). A person ordered by the court to undergo treatment and who is without a guardian may be transferred from one behavioral health provider to another behavioral health provider, as long as the medical director of the behavioral health provider initiating the transfer has established that:

- There is no reason to believe that the person will suffer more serious physical harm or serious illness as a result of the transfer;
- The person is being transitioned to a level and kind of treatment that is more appropriate to the person's treatment needs; and
- The medical director of the receiving behavioral health provider has accepted the person for transition.

The medical director of the behavioral health provider requesting the transition must have been the provider that the court committed the person to for treatment or have obtained the court's consent to transition the person to another behavioral health provider as necessary.

The medical director of the behavioral health provider requesting the transition must provide notification to the receiving behavioral health provider allowing sufficient time (but no less than 3 days) for the transition to be coordinated between the behavioral health providers. Notification of the request to transition must include:

- A summary of the person's needs;
- A statement that, in the medical director's judgment, the receiving behavioral health provider can adequately meet the person's treatment needs;
- A modification to the individual service plan, if applicable;
- Documentation of the court's consent, if applicable; and
- A written compilation of the person's treatment needs and suggestions for future treatment by the medical director of the transitioning behavioral health provider to the medical director of the receiving behavioral health provider. The medical director of the receiving behavioral health provider must accept this compilation before the transition can occur.

Transportation from the initiating behavioral health provider to the receiving behavioral health provider is the responsibility of the initiating behavioral health provider.